Aus der Universitäts-Kinderklinik (Jenner-Spital)
Direktor: Prof. Dr. med. E. Glanzmann

HYSTERIA IN CHILDREN

INAUGURAL-DISSERTATION
zur
Erlangung der Doktorwürde
der Medizinischen Fakultät der Universität Bern

vorgelegt von

Harvey Bertrum Feinberg

von New York, USA

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CHAPTER I
INTRODUCTION

This paper is designed to summarize the pertinent information available on the problem of childhood hysteria. It is not the desire nor the intention of this writer to present the multitude of theories and observations recorded in the literature, but rather to present, in a logical and systematic manner, a few pertinent causes and effects. It is the opinion of many authors that in fully 40 % of pediatric cases the neurotic element in the constitution plays an important role which, if neglected or ignored by the physician, will hamper or nullify all attempts to diagnose or to treat the disease. It is, therefore, hoped that this paper, by organizing the available information, will make a small contribution to the understanding of hysteria.

DEFINITION:

Hysteria is, by definition (53) a psychoneurosis, or a disease which has psychogenic origin. There is no underlying organic pathological basis and the manifestations are produced by conversion mechanism (i.e., emotions are transformed into physical symptoms). The emotional conflict which is responsible has been completely repressed, and the patient believes his symptoms to be the result of an organic disease process. The manifestations may be either brought on or altered by suggestion.

CHAPTER II
HISTORY

A. A Brief Summary of Child Psychology: Hysteria has been observed and discussed by physicians and scientists throughout the ages. Hippocrates (41) claimed that hysteria is due to the wandering of the uterus through the body in search of humidity. In the seventeenth century, the belief was that its striking manifestations were due to witchcraft or demoniacal possession. In fact, all mental abberation, up until almost the end of the 18th century, were regarded as due to sorcery, magic, religion and mysticism. Anyone, child or man, was thought to be possessed by evil spirits or the devil, and incantation, exorcism or punishment were the suitable means employed in their management.

There was very little actual psychological study of children, normal or abnormal, before the nineteenth century. The child was merely regarded as a miniature adult. Philosophers speculated about the nature and the mind of the child but practically no

scientific investigations were undertaken. Rousseau and Pestalozzi (15) began to focus attention on the education of the child. Rousseau opposed the strict rigid training to which the child was subjected at that time and encouraged a laissez faire attitude in dealing with children. Pestalozzi felt that powers of observation and perception should be encouraged and developed in the child. Froebel (15) believed that the child could develop his potentialities through activity if appropriate stimuli were available. These early hypothesis, although non-experimental, are of importance since they mark the beginning of a recognition of the child as an object worthy of attention and study for his own sake rather than as an undeveloped adult.

Tiedman in Germany in 1787, was probably the first to keep and publish a careful record of a child's growth. Darwin (41), in 1877, wrote a biographical sketch of an infant. Preyer, in 1881, published a very comprehensive work called Die Seele des Kindes. He carefully observed the reflexes present at birth and the development of more elaborate patterns of behavior during the child's early years.

John Sully (41), in 1895, may be credited with being the first to show interest in the imagination and play activities of children. He felt that a better understanding of their play would greatly increase knowledge of children.

However, there were practically no descriptions of actual mental disease processes until the later part of the nineteenth century. One by Paul Moreau, La folie chez les enfants, pointed out that overwork or too much education wears out children's brains. The physical causes include age, climate, temperament, sex and onanism, intoxication, and other physical diseases. The second was Manheimer's Les troubles mentaux de l'enfant, published in 1899. This author suggested prophylactic measures to parents and teachers; first, setting a good example and, second, loving and showing affection to the child.

Mention must be made of the pioneer work by Itard and Seguin (41) who were instrumental in establishing in France, Germany, and Switzerland, schools for the feebleminded.

To G. Stanley Hall (15), however, the greatest debt must be acknowledged. His guiding genius at Clark University, for so many years, provided the necessary inspiration for the application of scientific procedures to the study of children. This work, followed by Goddard and Healy, helped to establish the classical method of child guidance with its three-fold staff of psychiatrist, psychologist and social worker. Child guidance clinics have greatly multiplied in the world due to the impetus of these men.

No history of psychiatric maladjustment in children is complete without mention of the work of Adolph Meyer (43). Meyer felt that mental disease was more easily

prevented than cured. He proposed that child psychiatrists be placed in schools to cooperate with teachers in helping to bring about a better adjustment of their students.

B. Hysteria: The French schools were instrumental in calling attention to the problem of hysteria. Charcot (31) demonstrated that the dramatic manifestations of hysteria could be produced and allayed by hypnotic suggestion. He assumed that a hereditary degeneration was an essential prerequisite for hysterical phenomena.

Janet (31), a pupil of Charcot, developed the concepts of dissociation. Janat believed that certain mental processes were forced into the subconscious due to severe emotional shock or early childhood trauma. These mental processes then became cut off or dissociated from the main stream of consciousness. Hysteria, according to Janet, would be considered a defect, a negative process, rather than a dynamic, purposeful one.

Bernheim (41) emphasized the importance of suggestion and expressed the opinion that all hysterical symptoms were the result of suggestion.

Babinsky (15) amplified Bernheim's view by demonstrating not only that hysterical symptoms might be caused by suggestion but, in addition, they might actually be removed by counter suggestion. Babinsky claims that "Hysteria is a pathological state manifested by disorders which it is possible to reproduce exactly by suggestion in certain subjects, and can be made to disappear by the influence of persuasion (counter suggestion)."

It is universally agreed that hysteria is of psychogenic origin. The greatest influence towards the propagation of this point of view is to be found in the contribution of Freud (20). According to Freud, the wish, blocked in any direct expression, will obtain its gratification in disguised form through the mechanism of conversion by which the psychic conflict is transformed into a physical or mental symptom. The nature and localization of the symptoms thus produced in the hysteric will provide in symbolic or disguised forms an expression of the repressed wish. The hysterical symptoms will also produce some relief from the emotional conflict due to the alleviation of neurotic anxiety.

CHAPTER III

ETIOLOGY

The etiology of hysteria is extremely diverse. All of the following may play a role in its development.

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CHAPTER III

ETIOLOGY

The etiology of hysteria is extremely diverse. All of the following may play a role in its development.

1. Parental Attitude: In the first year of life, nothing is so important as the child being given love, affection and consistent handling.

2. Separation in Early Life: Evidence is present that prolonged (say, upwards of two to three weeks) separation from the mother predisposes the child to emotional atrophy.

3. Position in the Family: The eldest child has a mother who is inexperienced and apt to take everything too seriously. The youngest stays the baby and is never succeeded, while the middle of the three has often to establish himself against bilateral competition.

4. Physical Disabilities: Intercurrent illness brings with it its own problems, and it may make an already anxious parent still more inclined to over-react, or it may induce a feeling of irritation and frustration towards a child who is repeatedly ill.

5. Stresses Outside the Home: It sometimes becomes clear that the child's difficulties have more to do with school than home. They may not be able to tolerate the mild degree of "beating" which is liable to come their way. There may be some degree of educational retardation because of average ability but poor achievement.

Constitutional and physical factors (3) must be excluded before the diagnosis of hysteria is made. It has often been found that many cases of organic disease in children are overlooked. The frequency of various types of encephalopathies that may complicate or follow acute infectious diseases occurring in infancy and early childhood, with resultant behavioral and personality changes has been stressed by many investigators. It is safe to say that if all children with psychologically deviant behavior were subjected to an intense neuropsychiatric examination, many cases of organic disease would be uncovered. It is possible that the inability of psychiatric treatment to reach the child may, in some cases, be due to underlying organic pathology.

With regard to constitutional factors (24) there is also an increasing body of knowledge which points to the possible involvement of physiological and chemical factors in the etiology of behavior disorders. ACTH has produced profound personality disturbances such as delusions, hallucinations, depression and excitement in children. The state of glutamic, as well as lysergic acid, which paralyzes the sympathetic nervous system, and produces a psychotic picture, is still being studied. These probably operate by producing changes in the enzyme system involved in brain tissue metabolism.

The role of the ductless glands (24) must also be excluded before the diagnosis of hysteria can be made. It is well known, for example, that increased functional

activity of the thyroid produces excitation, a state of anxiety, disturbance of character, and of general sensibility. On the other hand, diminution in the activity of the same glands produce, on the contrary, depression or apathy. The parathyroids may also produce certain convulsive phenomena. Castration in females is also apt to produce a state of disordered equilibrium.

Disturbance in the function of the pituitary glands lead to profound nutritional deviations, to mental depression and the lowering of mental faculties.

Chronic parental intoxication invariably produces poor progeniture. Alcoholism, morphinism, cocainism, are well known agents which, being absorbed by the parents for a prolonged period, endanger children and may produce either gross mental or physical anomalies. In addition, an unstable, irregular and deviated nervous system with abnormal tendencies may also result.

CHAPTER IV
PSYCHOPATHOLOGY

According to Freud (20), the symptoms of hysteria are the result of a conflict between the super-ego and some "wish" not acceptable to the super-ego, which the latter represses. The repression, however, is only partially successful; the wish, although repressed into the unconscious, succeeds in obtaining a disguised expression by "conversion" into hysterial or bodily symptoms.

CHAPTER V
HISTORY-TAKING AND EXAMINATION

It is best to take the history (2) in private and away from the child. The physician, while interviewing the parent, should create an informal situation in which a troubled individual will feel free enough to admit to the doctor, something of what is worrying him. Casual remarks may hint at family attitudes which may be of the highest relevance.

It is just as important to try to make some contact with the child as it is to get behind the parent's defense system. Many children will use paper and pencil if given the opportunity and will often tell the physician a good deal about themselves in the drawings they make while waiting outside. Active play, however simple, is always more revealing than books or puzzle games.

CHAPTER VI

SYMPTOMS

There are no physical signs or symptoms (52) in hysteria that could not be produced in the beginning either by volition or by emotion. There may be long-standing contracture, for example, which may persist during sleep and anaesthesia, or there may be paralysis which is always of an entire limb or of a movement, and never of an individual muscle. A tic (49) is always a coordinated movement of synergic muscles, never a chaotic movement of muscles not functionally associated, an anaesthesia is of the "glove" and "stocking" variety and does not follow a segmental peripheral nerve distribution. The determination of whether the basic cause is actually psychological rather than organic is difficult, often involving careful study by a number of medical and psychiatric experts. Even after careful study, the specialists may not agree. The situations which threaten the young child are often of a complex or indefinite kind, and the means of responding, at his disposal, are few and unstable. For these reasons, disorganization of behaviour are relatively common in childhood.

The hysterical symptom (30) may be regarded as expressing a conflict or an idea in symbolic form. The symptoms serve to prevent or lessen any conscious, felt anxiety and usually symbolize the underlying mental conflict which is productive of anxiety. The symptoms provide some form of solution for his problem and afford him a certain amount of relief from the anxiety involved in the situation. These symptoms are characteristic of hysteria in both children and adults.

The existence of organic symptoms does not preclude the presence of hysterical manifestations. Symptoms of organic disease that still exist may be exaggerated or symptoms may persist after the organic basis for them is no longer present.

Hysteria is a psychic disorder characterized by great emotional and reflex excitability. It produces an almost uncontrollable desire to attract attention and gain the sympathy of others. These children are greatly influenced by suggestion or autosuggestion which may produce perverted ideas. The symptoms are numerous and varied and not all are exhibited in any one case. They serve the purpose of arousing attention and exciting the sympathy of parents as shown by the fact that the manifestations are most urgent when the patient is in the presence of others. The symptoms may be divided as follows:

1. Sensory Symptoms: Hysterical headache (26) or pain in other regions, are most likely to develop at a time when it will be of advantage to the child. It is not intentional and malingering, but the result of a subconscious impulse. Occasionally one sees pain in the joints. There may be changes in sensation not corresponding to

organic nerve distribution. As a result, anesthesia extending to the midline or even beyond it may manifest itself. There is absolute loss of cutaneous sensations The borders of the anesthetic areas are sharply defined, but they may vary from examination to examination. Despite marked anesthesia, these children can identify objects and can perform skilled movements and fine acts for which cutaneous sensations are indispensable, and they may retain postural sensation even though all other sensations are lost. These children are often very suggestible, and a skilled examiner, if he so wishes, can easily suggest glove and stocking and midline changes. In hysterical individuals, there are areas of hyperaesthesia, especially in the inframammary region, over the ovaries and over certain joints.

2. Motor Symptoms: Hysterical general convulsions (5) have been observed, but are usually not seen before late childhood. Motor tics involve a coordinated group of muscles. Hysterical movements are apt to be more coordinated than those of true chorea and to be less varied. There may be paralysis with or without contractures. There may be rigidity similar to voluntary rigidity, and it is difficult to differentiate the two. Such rigidity is usually of wide and possibly long duration. There may be an extreme degree of opisthotonus. The manifestations may simulate decerebrate or catatonic rigidity. Fine tremors may be psychologically initiated in tension and apprehensive states. A fine tremor of the closed eyelid is also seen in hysteria. In hysterical states the eyes may be kept tightly closed and the patient resists an attempt to open them; he may, however, open his eyes and make furtive glances where he is confident of being unobserved.

3. Special Senses: At this point, hysterical deafness (4), perhaps following a blow on the ear, may be mentioned. Usually this is not common at this early stage of life. Anosmia sometimes occurs along with other anaestheseas, usually taste is not affected, however, anosmia is often present in true hysteria. A concentric diminution of the visual field is not uncommon. Amaurosis and amblyopia (1) may also occur. Hysterical blindness often appears suddenly and without much previous notice. In the normal individual, the field of vision widens progressively as the test objects are held further away from the cornea, but in hysterical individuals the normal widening is not seen, and the entire width of the field is as great at one foot from the cornea as it is at two, five, ten or fifteen feet. Astasia-Abasia is sometimes observed in hysterical individuals. There is often marked swaying from side to side. There are superfluous movements, and the patient may fall far to the side, or to the front, or to the back when walking. If he falls, it is in a theatrical manner without injury to himself.

4. Visceral Symptoms: Anorexia Nervosa (8) is one of the common symptoms. The patients reach an extraordinary degree of emaciation and if not rescued in time may become mere skeletons and eventually they succumb to tuberculosis.

Excessive appetite, vomiting, hiccough, fullness or pain in the epigastrium, flatulence and regurgitation also occur as visceral symptoms.

5. Vasomotor Disturbance: The hysterically paralyzed limb is often blue and cold. Partly due to the result of disease and of improper posture. Emotional flushing or else pallor have also been observed. Exaggerated irritability of cutaneous capillary vessels, urticaria from the least irritation of the skin.

6. Respiratory Functions: There may be attacks of dyspnoe or asthma, with attacks of spasmodic cough.

7. Genito-Urinary Symptoms: There may be spasmodic retention of urine, frequent urination and some cases of enuresis.

8. Mental Symptoms: There may be amnesia (the dropping out of a circumscribed series of events). Dizziness is a common symptom in hysteria and anxiety states. There is no nystagmus found, but the dizziness is usually associated with a state of anxiety.

CHAPTER VII
DIAGNOSIS

The pediatrician is faced first with the problem of differentiating between hysteria and organic abnormality. Consequently, all efforts should be made to make a correct diagnosis. Hysterical symptoms may occur in early childhood but only in situations with which the child is familiar. For example, the young child may complain of a headache, stomach ache or weakness of the legs when these symptoms may be used as an escape from school, and thus avoiding the danger with which going to school may have become associated. However, these symptoms rarely become fixed or fully relieve his anxiety.

Many mothers place obstacles in the path of a pediatrician, since with their many defenses, they are unwilling to admit that the real trouble lies with her. Hence, a pediatrician must rely on limited observations and reports from parents.

The diagnosis of hysteria can be made only after all possibilities of organic involvement have been eliminated. A sympathetic, understanding attitude should be assumed, and the tests to rule out organic disease should not be too exhausting as they may add anxiety to an already emotionally charged situation.

Hysteria may be diagnosed if there is absence of objective physical signs to substantiate the patient's subjective symptoms, evidence that the complaints had their

onset in association with either emotional stress or suggestion. In addition, there should be some presence of personality traits, stigmas (glove and stocking anesthesia, absence of pharyngeal and conjunctional reflexes), and finally the therapeutic response to suggestion (14). There may be, in some patients, the presence of bizarre tremors, vasomotor instability (hyperhidrosis of hands and feet) and pronounced dermatographia.

It is necessary for early recognition and proper evaluation of the hysterical state, for if it is not corrected then the disease process will become more intense and better organized as the individual advances into puberty and adolescence.

CHAPTER VIII
TREATMENT

The development of later hysterical episodes can be prevented if modern psychotherapeutic methods (non-directive therapy) are applied early (33). The younger the patient the greater is the mental plasticity and the beneficial effect of proper education and environmental therapy. If possible, treatment should start before the age of six years. The relationship of child and mother is fraught with emotional overtones and must be thoroughly investigated. Most children are susceptible to the usual guidance technique and there is a favorable prognosis.

Advancement of knowledge (35) has broadened the concept of the function and scope of pediatrics. The physician can now help to develop not only the best organic mechanism but also the most satisfactory personality of which the child is intrinsically capable.

A mentally healthy child (38) is one who is growing in self control and self direction toward social ends, who is developing an adequate personality, and who is growing mentally and emotionally toward maturity. However, such symptoms as lying, truancy, enuresis, fears, temper tantrums, jealousy or negativism usually point toward insecurity. Fostering security is, therefore, good prevention for hysteria as well as other behavioural deviations.

Independence appropriate to age can be achieved by not regimenting infants into fixed schedules and rigid techniques, but by recognizing individual growth patterns and by helping children take the next step as indicated by their own developmental time table. Given safety, freedom and encouragement, a child will progress in stages appropriate to their level of maturational development. Any attempt to force behavior before the child is ready for such stimulation is doomed to failure.

Patient and tactful discussion with parents which point out the principles involved in good mental hygiene practice should be encouraged. Inestimable value to the parents can be accomplished by such discussions with the pediatrician.

Psychiatry combined with pediatrics now offers a body of knowledge which can be applied to general medical problems. The period of childhood is the important time to develop a healthy approach to life. Preventive pediatric services should be enlarged to include care of emotional insecurities and the avoidance of conflicts inherent in the rearing of babies and young children as members of a family unit. Skill in managing the emotional problems of infancy and childhood will often prevent more serious disturbances at a later period of life.

It is within this basic pattern of dependence on the parents and the slowly increasing independence that the emotional development of the child can best proceed.

The disturbed child is a delicate barometer reflecting the emotional tension within the family. It is probably valid to conceive of the symptoms of the child as expressing the family "pathology". The disturbed child is a symptom of disturbed family relationships.

It might be desirable, particularly in the short contacts possible in general practice, that the main therapeutic orientation be directed towards the parents (52). It would be beneficial for the physician not only to consider them as parents and from this standpoint to evaluate their relationship to the child but, in addition, to consider them as individual persons with their own unique emotional problems.

There are a number of attitudes on the part of the physician which he may unconsciously assume towards the parents and the child that may diminish his usefulness in helping them. He may even exacerbate an already tense situation. The physician may have, even unconsciously, a critical attitude toward the parents which will increase their sense of failure and at the same time create in them a feeling of defiance and hostility. The physician might tend to assume an authoritarian somewhat dictatorial role in which he orders the parents to behave in ways which at that time, may be psychologically difficult if not impossible. He may attempt to offer advice on which the parents are unable to act because of their own unresolved emotional problems. The physician may attempt to overidentify himself with the child and to think and act in the erroneous terms of the good child versus the bad parents.

Perhaps the one most important quality for the physician to acquire in developing an effective therapeutic approach is the ability to listen (45). In many instances, the best medicine a physician can offer to a parent is 15 or 20 minutes of attentive listening. If he can achieve a non-critical attitude and can help the parents express their own anxieties, uncertainties, feelings of guilt and other emotions, for which

they already condemn themselves too severely and about which they are already too ashamed. By this technique of "uncritical listening" he can serve to alleviate the tensions within the family and thus indirectly be of greater help to the child.

As for medical treatment of the child (29), nutrition of the proper kind is one of the first requisites in restoring and maintaining a healthy nervous system balance. Second, long hours of rest are necessary to allow for repair and the storage of energy. These two factors alone, if properly applied, will in most instances meet the requirements of the nervous infant. Later on, as the child begins to show mental alertness, it is the parents who need most of the supervision. Lack of knowledge on the part of parents in dealing with the nervous child is a potent cause for increasing rather than abating the condition. The instincts and habits of the child should not be suppressed. He should not always have his way, but it should not be the way of the adult but rather the way of the child when we do permit freedom. The habits and manners of childhood should not be interfered with, as such hampering is a great factor in causing nervousness. This interference tends to intensify even more an already nervous child.

To expect any results at all, one must necessarily apply his efforts at the earliest possible period of the child's life. The child should be surrounded by individuals who are capable of self control, who are not unduly irritable or too emotional. If the child is breast fed, the nursing person must be extremely hygienic in her mode of living and be especially free from the use of alcoholic beverage. Fear and the lack of sense of security are extremely strong in the "nervous child". The child should be taught how to feel secure. By giving him freedom of movements, instead of keeping him away from play for fear of exposing him to possible accidents, one should, on the contrary, conquer timidity and urge physical exercise within the limits of his strenght and constitution.

The pediatrician must always be mindful of the excessive timidity of these children. One must avoid stimulating their imagination with the recital of emotional events. The same may be said of their extreme suggestibility; the choice of reading matter or of lectures must be made very cautiously. Literature full of romantic, erotic, or pornographic incidents must be avoided, because they create emotional shocks, ideas of vanity, dreams of a grandiose nature, mystic tendencies, and thus render the mental state incapable of adapting itself to reality.

One must always bear in mind the fact that severe education and punishment destroy any trace of initiative in a sensitive child. Opportunities for initiative should be afforded rather than forbidden, efforts must be made to develop the aptitudes they possess.

Changes in the child's intellectual and emotional structure may also occur following infectious diseases (42), such as measles, typhoid fever or encephalitis lethargica.

Toxic states of gastro-intestinal, hepatic or renal origin many create a cerebral irritation accompanied by disturbances of disposition and impulsive acts. The physiological processes of growth, anemia, chlorosis, nutritional disturbances of any origin, physical and mental exhaustion - are all additional factors which by themselves are apt to produce manifest changes in the child's disposition, behaviour and propensities. In all such cases one should suspect some organic disorder which, of course, requires medical treatment.

Occasionally, a more radical treatment (54) may be effective. A shock or surprise; as when a child with hysterical paralysis is ordered firmly and repeatedly to get out of bed; or possibly even the use of a strong electric current which will produce pain. These therapeutical procedures are sometimes risky, for if it fails, our influence is ended. However, they are well worth considering for good results have been reported in the literature.

The general practitioner who decided to attempt remedial procedures should be aware of certain conditions which might interfere with the therapeutical process. For example, it is certainly counter indicated for a practitioner to attempt anything with a family which is divided against itself or in which the material circumstances are of such a nature that they almost prohibit normal psychological growth.

The role of the family doctor is, therefore, likely to be twofold. He will be called in early to advise on the first stages of a problem, and he may from time to time be in a position to forestall a problem by his handling of intercurrent illness or upset. The best therapeutic measure for the doctor is suggestion. The object is to bring back to consciousness, against more or less "resistance" by the patient, the mental events which have been associated with the development of symptoms.

In a great majority of cases (55) it is possible, by giving the child confidence, and by exercise of firmness as well as tact, to persuade him that the lost function is recoverable, that he can move his hitherto rigid arm, or walk upon his seemingly powerless legs.

The psychoanalytic treatment requires recalling the trauma, which brought about these symptoms, of counteracting the tendencies to avoid the situation associated with a trauma, to modify and correct his attitude towards the situation, and finally, to teach him new, more positive techniques of control over it.

In the treatment of hysteria (32), the psychiatrist attempts to ascertain the purpose of the symptoms, to discover the facts which caused anxiety so great that it could be handled only through the mechanism of conversion. Since the child's disorder arose through mental causes and through the operation of mental mechanisms, then the treatment should basically be that of psychotherapy. The methods applied may be that of suggestion, hypnosis and reeducation. In some cases, psychoanalytic

treatment takes so long that the child's education is seriously interrupted. With children, therefore, the short term or suggestion therapy is recommended.

In summary, the doctor, before he decides whether he will treat it himself or send it to the clinic, must seriously consider the following factors:

1. Stable Family Background: It is very important to determine whether there is a stable united family, anxious to help and not unduly perturbed by the problem. It is important for the doctor to relieve both parents and children of some of the sense of failure. It is probably inevitable that some of the resentment felt towards themselves and other members of the family unit will be directed towards the physician. He should be prepared for, and be willing to accept, some of this hostility.

2. Limited Crisis: Evidence that the disturbance is a passing phase and not a sign of a more serious pathology.

3. Differing Standards: The extent to which a problem is localized. Whether it is in the home or at school.

CHAPTER IX
CASE HISTORIES

I have chosen five case histories from the files of the Jenner hospital as examples of typical cases of hysteria. They will serve as a guide and a comparison for the interested pediatrician.

Patient No. 1

Case No. 890 - V.G., a twelve year two months old girl was admitted to the hospital on October 21, 1949, because of tiredness, increased need for sleep, loss of appetite and headache. The organic findings were as follows: An X-ray of the skull disclosed a small skull, an extremely large struma nodosa as well as a Basal Metabolism of -25. The patient produced on two occasions, after psychological stimulation, a typical tetanie as a result of hyperventilation. The tetanie was promply healed after an intravenous injection of calcium. The attention was at first depressed, sad, and extremely withdrawn; however, she was oriented and aware of events. The patient was extremely sensitive and reacted, when she felt rejected, with organic symptoms such as headache, vomiting, or feeling of weakness in the extremities. The patient's symptoms, however, were easily turned aside. In general, she was easily influenced and by the method of simply keeping her busy, the physician was

able to minimize the patient's symptoms. She had a mongoloid sister and a sick grandmother who exerted too great an influence upon her home life. The patient also had a trauma a few months previously when she was run down by an automobile. The symptoms, combined with her history, indicated that the simple therapy was indicated. This proved successful and tended to substantiate the diagnosis of hysteria.

The organic symptoms were treated with Benadon, Hypophysin, and Ferri Iodat.

When the patient was discharged she had a good appetite, had gained 1.4 kg., and had no abnormal symptoms.

Patient No. 2

Case No. 350 - S.H., an eleven years five months old girl was admitted to the hospital on March 28, 1949, with the following history:

She awoke one morning with no apparent disturbance. She was seen by her father in the village about 9: 15 on her way to school. She appeared happy and was talking cheerfully with her friends. A quarter of an hour later, instead of being with her teacher, with whom she had an appointment to discuss the results of a previous examination, she was at home and complained that she could no longer walk. The child did not complain of pain in her legs, but rather that she could neither stand nor walk. By supporting herself she was able to walk and was extremely cheerful. She said that twice before she had fallen in the village and was carried home. The doctor expressed the opinion that it might be poliomyelitis and the child was admitted to the hospital with this tentative diagnosis.

The child was somewhat nervous and incoherent. She was an average student, and her teacher felt she had nothing to fear about the coming examination. In class, she never expressed any fear. At home, however, she was not very diligent with household duties. Invidious comparisons were constantly made between herself and her older sister who was much more conscientious. Her parents complained that she was not particularly ambitious.

Objective strength in both the child's arms was good. The girl could also stretch her legs well against resistance.

The child could, upon demand, jump and even walk without limping.

The reason for the symptoms was perhaps the change of teachers which was about to take place, plus going to a new school which would mean a change of atmosphere. This was directly expressed neither by the parents nor the child, however, by speaking to the child and piecing parts of the history together, one was able to uncover the basic difficulty. Therapie, therefore, consisted of suggestion that she was well, and she was soon discharged.

Patient No. 3

Case No. 237 - P.J.P., a six years three months old boy, was admitted to the hospital on Feb. 12, 1952, because of feeding difficulties He refused to eat and complained about body pain particularly localized in the region of the stomach. One doctor diagnosed it as a stomach ptosis and another disagreed. From 3 1/4 to 5 1/2 years of age, the child was in a hospital for observation and therapy. There was no improvement of the child's condition during this time. In fact, the opposite; his condition deteriorated and the child ate even more poorly and vomited frequently. About four months before admission to the Jenner hospital, the child fell on his head. After this trauma, the child vomited even more frequently. A connection between the accident and the vomiting was not established. The child was not unconscious after the accident, and he did not complain of a headache. The month before admission the condition became even more serious. The X-rays of the gastro-intestinal tract showed nothing abnormal. The diagnosis of hysteria was made, and the patient was placed on a diet of fruit juice, because of the anorexia. The symptoms, after proper suggestive therapy, were soon alleviated.

Patient No. 4

Case No. 212 - S.A., an eleven years seven months old girl, was admitted to the hospital on February 10, 1954, because of a lung infiltration following pertussis. As well as the complication of a lung infiltration, the patient at the time of entry, suffered from a congenital heart vitium. It was to be determined whether the heart vitium could be corrected. On testing for any abnormality of the nervous system, it was found that when the child was touched on the right leg with a wad of cotton there was a loss of sensation. On no other place on the body was there found to be any loss of sensation. Pain sensation was not found to be diminished. By testing the toe reflex, the child claimed she had no feeling as to which side the toe moved, but she did have the feeling that it moved. The diagnosis was made of hysterical hemianaesthesia which was in the declining stages. Therapy consisted of pine needle baths, ichthyol applications, and Saliten B.

Patient No. 5

Case No. 41 - I.V., a fourteen years seven months old boy, was admitted to the hospital on Dec. 23, 1952, with the following history:

Since the age of one he has had epis les every night and occasionally during the day, of partial unconsciousness with dyspnoe. He became blue and had a great deal of foam on his mouth. He had convulsions that began always in the neck and thorax.

He screamed, got out of bed and once wanted to throw himself out of the window. The family doctor treated him for a year with calcium injections. The injections at the beginning helped, but before admission to the hospital they were becoming less helpful. At home, when a stranger was in the house, the child felt well and much less restless than when just members of the household were present.

In the hospital, there were episodes of shaking, but no fits. He would consciously stop breathing and his face would become red. His pulse was strong with a frequency about eighty. He said he had a feeling he was suffocating and there was a tightness in his neck. He showed a great deal of fear that he could no longer breath. His reflexes were increased but there was no Babinski. Consciousness was always normal and one could speak with the child and be answered rationally; his body, however, shook constantly, but there was no outbreak of sweating nor foam before his mouth. By comforting him the shaking stopped, and his breathing became quiet.

For the episodes of dyspnoe, no organic cause was found. There was, however, a history of conflict. One was the fear that his sick mother would die and his future would, therefore, be insecure. The other was his difficulties in school. Treatment in the hospital was purely symptomatic, consisting of Coffadyn, Rectoquintyl suppositories, Bellergal and tincture Opii. Psychotherapeutic treatment was recommended, and the child was discharged.

SUMMARY

1. The case histories of three girls and two boys with the diagnosis of hysteria were reported.

2. The ages of the children varied from six to fourteen years.

3. The symptoms consisted of vomiting, headache, weakness in the extremities, inability to walk, refusal to eat, loss of sensation of the toes, episodes of shaking and dyspnoe.

4. The family history usually revealed a conflict situation with the symptoms being an attempt at resolution.

5. Treatment, wherever possible, consisted of suggestion therapy. For more deep seated problems a psychiatrist was consulted who then took over the management of the case.

CHAPTER X

SUMMARY

The hysterical symptoms of infancy and childhood are extremely important and they are worthy of careful study by every physician coming into contact with children.

Hysterical symptoms in children appear to be determined largely by the influence of suggestion coupled with the desire for self-assertion, sympathy or escape. In an unhappy environment, many things can serve as catalyzing agents. Some unusual circumstance, a change in the child's psychological world, an emotional strain, can produce the picture of hysteria. Basically, the symptoms make possible an escape from an intolerable situation; or they may afford an exoneration for oneself, an excuse for one's failure. In some cases, they enable one to evade some duty, avoid a responsibility, express some spite, for a real or imagined injustice, serve as an attention-getting device, or realize some purpose which would not bear the harsh scrutiny of consciousness.

It may be stated that the clinical picture of hysteria based on the characteristics presented at hospitalization are the following:

1. The illness is multi-symptomatic.
2. The duration of the illness prior to hospitalization for the first time is measured in months or years and not days or weeks.
3. The "classical" pseudo-neurologic symptoms of hysteria are abdominal pain and vomiting.
4. Nervousness or the so-called somatic symptoms of "anxiety" (palpitation, breathing, difficulty, paresthesia, dizziness, fatigue and weak feelings) are a constant feature.

The above symptoms singularly, or in combination, would point strongly to a diagnosis of hysteria.

It is claimed, that the onset of hysteria is unusual before the age of nine and rarely seen below the age of five.

The pediatrician's role is:

1. Early evaluation of symptoms and diagnosis.
2. A preventive type of guidance.
3. Referral for psychotherapy and follow-up study as directed by the therapist.

The pediatrician with his knowledge of the environment and the child's relationship with the various members of the family can be an available instrument in the therapeutical process.

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The method of handling difficult children has been designated child guidance and is a technique which calls for the team effort of pediatrician, psychiatrist, psychologist and social worker Each group, with their special training and skills, can make their own unique contribution to our understanding of hysteria. Each, however, must make this contribution by the application of their own special techniques without encroachment upon the field of the other team members. This paper has been primarily concerned with the role of the Pediatrician in this cooperative therapeutical effort. Working together they can help to solve the problems of the child and guide our youth through adolescence into healthier, more useful, and productive adulthood.

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